GRINBAUM
ORTHODONTICS

DATE_____
PLEASE LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE. LIST MULTIPLE SOURCES IF APPLICABLE. DOCTOR PATIENT PAPER/MAGAZINE DRIVE BY

NAME OF REFERENCE

_____

PATIENT INFORMATION

Name _____Birth date _____Age(___) Sex: Male Female
Address_____City_____
State_____Zip_____ Home Phone (____)_____
Work Phone (____)_____Cell (____)_____.
E-mail address_____
If patient is a student, Name of School

_____

Person to contact in case of emergency:
Name_____
Relationship to Patient:_____

RESPONSIBLE PARTY

Name_____
Relationship to Patient_____
Address_____City_____
State_____Zip_____Home Phone (____)_____
Work Phone (____)_____Cell (____)_____
E-mail address _____

Circle the Appropriate Status: Single Married Divorced Widowed Separated

Drivers License # _____ State_____ Exp Date _____

INSURANCE INFORMATION

If you wish to have our office submit your dental claims for you, please fill this section out completely.

Primary Dental Insurance

Name of Policy Holder_____
Relationship to Patient_____ Birth date_____.
Social Security /ID#_____
Employer_____
Work Phone_(____)_____
Insurance Company_____
Group #_____
Address_____City_____State__
___Zip_____

Phone (_____)_____

Secondary Dental Insurance

Name of Policy Holder_____
Relationship to Patient_____ Birth date_____.
Social Security/ID # _____
Employer_____
Work Phone_(____)_____
Insurance Company_____Group
#_____
Address_____City_____State_____
Zip_____

Phone (_____)_____

DENTAL HISTORY

Former/Current Dentist_____ Date of
last dental X-rays_____
Address_____City_____State____Zip_____
Phone(____)_____
Has Patient had any of the following: !_____!_____!_____

__ Bad breath
__ Grinding teeth
__ Bleeding gums
__ Loose teeth or broken fillings

MEDICAL HISTORY

__ Clicking or popping jaw __ Periodontal treatment __ Food collection between teeth __ Sores or growths in mouth

Sensitivity:
__ Sensitivity when biting __ Sensitivity to cold
__ Sensitivity to heat. __ Sensitivity to sweets

Address_____City_____State____Zip_____.
_Phone(____)_____
Has patient ever had any serious illnesses or operations? Yes No ------ If yes, describe type and date:
_____

Check if patient has had any of the following: (initials)

(If none, indicate here:) NONE_____

__ADD/ADHD __AIDS/HIV __Anemia __Asthma __Cancer __Cerebral Palsy __Chicken Pox __Diabetes __Epilepsy/Seizures __Eye Disorders

Medications:

__Extreme nervousness __Hearing Problems __Heart Ailments __Hemophilia __Hepatitis __Hives

__Kidney Problems __Learning Disability

__Liver Problems __Measles
__Mental Retardation __Mononucleosis __Rheumatic Fever __Psychiatric Care __Sinus Problems __Physical Handicap __Tonsillitis

Allergies:

Correlating diagnosis:_____ _____

Does your child take vitamins with Fluoride Yes_____ No_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that

Signature_____Date_____
Relationship_____

********** Reviewed by Doctor_____

__Thyroid Disorders
__Ulcer or Colitis

Other/Details: _____ _____ _____

List medications patient is taking _____